

LOCAL GOVERNMENT ANNUITANT OR CONTINUANT ONLY

Instructions:

To change plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

PLEASE PRINT

GROUP: LOCAL GOVERNMENT ANNUITANT OR CONTINUANT			DUAL-CHOICE			HEALTH INSURANCE APPLICATION			
Applicant – Last Name			First		Middle I.		Social Security Number		
Address – Street & No.			City		State		ZIP Code		County
Home Telephone Number			Area/No.						
Marital Status	Married		Divorced		Separated		Widowed		
<input type="checkbox"/> Single	<input type="checkbox"/> Date _____		<input type="checkbox"/> Date _____		<input type="checkbox"/> Date _____		<input type="checkbox"/> Date _____		
Spouse's/Ex-Spouse's Name & Social Security Number				OTHER HEALTH INSURANCE COVERAGE (<i>You must complete this section</i>)					
CURRENT GROUP HEALTH INSURANCE PLAN Plan Name _____ Group No. _____				Are you or a family member insured under Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes					
				If yes, list names of insured and Medicare effective dates. Name: _____ Dates: Part A _____ Part B _____ Name (spouse): _____ Dates: Part A _____ Part B _____					
NEW GROUP HEALTH INSURANCE PLAN SELECTED Plan Name _____ <i>(list complete name, including location if part of name)</i>				Are you or a family member insured under another health insurance plan? <input type="checkbox"/> No <input type="checkbox"/> Yes					
				If yes, list names of insured and plan. Name: _____ Name (Spouse): _____ Plan Name (Insurance Co.): _____ Group No.: _____ Subscriber (Policy) No.: _____ Name of Employer: _____					
COVERAGE DESIRED									
<input type="checkbox"/> Single <input type="checkbox"/> Family									

Last Name	First	Middle I.	Birthdate			Sex	Social Security Number	Appl. Rel. Code (see page H-2)	YOU MUST INDICATE SELECTED PRIMARY PHYSICIAN, COUNTY in which located, and PROVIDER NUMBER (if available). Indicate NONE if electing the Standard Plan.			CARRIER USE
			MO	DAY	YR	M/F						PRS Code
									PHYSICIAN NAME	PROVIDER/ PHYSICIAN COUNTY	PROVIDER NUMBER	
Applicant								N/A				
Spouse								N/A				
Eligible Dependent(s)												

Return completed form to:

EMPLOYEE TRUST FUNDS
 P.O. Box 7931
 Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be effective 01/01/2003

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. **Submit form with original signature.**

<input type="checkbox"/> I am a retiree or surviving spouse/dependent <input type="checkbox"/> I am on continuation (eligible for a maximum of 36 months' coverage)		DATE SIGNED (MM/DD/CCYY)	SIGN HERE	APPLICANT SIGNATURE
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FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY								
ENROLLMENT TYPE		EMPLOYEE TYPE		COVERAGE CODE		CARRIER SUFFIX	PARTICIPANT'S COUNTY	PROVIDER'S COUNTY
40								
EIN			Group Number		ETF Contact Person		Telephone (608)	
0000-001			77					
Monthly Premium				Date Received		COBRA Coverage Expires		Effective Date
\$								01/01/2003
FOR CARRIER USE		SN		FN		PL		ED
								Premium Source 01 02 03 04

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.
2. I agree to pay the current premium for this insurance.
3. I agree that any physician, hospital, or other institution who attends or has attended me, my spouse, or any of my children is authorized to furnish the insurance carrier with any and all information including the history obtained, findings and diagnosis. I authorize ETF to obtain all necessary information from the insurance carrier.
4. Any children listed on this application are unmarried and dependent on me, or the other parent, for support and maintenance. If over the age of 19, they are a full-time student; if over the age of 25, they are disabled of long standing duration and are incapable of self-support.
5. I understand that coverage will be cancelled and cannot be reinstated if premiums are not paid when due.